



Commonwealth of Massachusetts Motor Vehicle Crash Operator Report

When should I complete a Crash Report?

M.G.L. Chapter 90, Section 26 requires a person who was operating a motor vehicle involved in a crash in which (i) any person was killed or (ii) injured or (iii) in which there was damage in excess of \$1,000 to any one vehicle or other property, to complete and file a Crash Operator Report with the Registrar within five (5) days after such crash (unless the person is physically incapable of doing so due to incapacity). The person completing the report must also send a copy of the report to the police department having jurisdiction on the way where the crash occurred. If the operator is incapacitated but is not the vehicle's owner, the owner is required to file the crash report within the five (5) days based on his/her knowledge and information obtained about the crash. The Registrar may require the owner or operator to supplement the report and he/she can revoke or suspend the license of any person violating any provision of this legal requirement. A police department is required to accept a report filed by an owner or operator whose vehicle has been damaged in a crash in which another person unlawfully left the scene even if damage to the vehicle does not exceed \$1,000.

How To Complete This Form

Please carefully complete all sections of this form that apply to your crash, circling the answer where appropriate. Illegible reports will be returned to you.

Section A: Crash Location

- Provide the city/town where the crash occurred, the date and time of the crash, and the number of vehicles involved.
- Complete section A1 or A2.
- Use official names of all locations, streets and landmarks.
- Use street name and route #, if applicable.
- Be as precise as possible when describing the location.
- Provide enough information to locate the crash to a specific point, not just a street or roadway.

Section B: Vehicle You Were Driving

- Provide information on your license and the vehicle you were driving.
- Use the codes provided to indicate the cause of the crash.

Section C: You and Your Passengers

- Provide information on you and your passengers at the time of the crash.
- Use the codes provided to indicate occupant information.

Section D: Other Vehicles Involved in the Crash

- Provide information on the other vehicle(s) and operator(s) involved in the crash.
- If more than one vehicle involved, please use additional form completing Section D only.

Section E: Non-Motorist(s) Involved

- Provide information on the non-motorist(s) involved in the crash.
- If more than one non-motorist involved, please use additional form completing Section E only.

Section F: Crash Conditions

- Use the codes provided to indicate the conditions at the time of the crash.

Section G: Crash Diagram

- Draw a diagram of how the crash occurred.
- On the diagram, Vehicle 1 represents your vehicle.

Section H: Witness Information

- List all the people who saw the crash but were not involved.

Section I: Property Damage Information

- Indicate all non-vehicular property that was damaged in the crash.

Section J: Description of What Happened

- Describe the crash including events prior to the crash for your vehicles and all other vehicles.

Section K: Signature

- Please sign and print your name and indicate the date you completed the form.

Where to send completed reports:

Mail or deliver one copy to the local police department or state police in the city or town where the crash occurred.

Mail one copy to your Insurance Company.

Mail one copy to the RMV at the following address:
Registry of Motor Vehicles
Crash Records
P.O. Box 55889
Boston, MA 02205-5889

A. Crash Location

A1. City/Town Where Crash Occurred **A2.** Date of Crash **A3.** Time of Crash AM PM **A4.** # Vehicles Involved:

Please complete Section A1 or A2 below to indicate the location of the crash. If you need additional space to describe the crash location, please use Section J on the last page of this form.

A5. Did the crash occur at an intersection of two or more streets? Yes No

If Yes. **Step 1.** Please indicate the route or roadway where you were travelling when the crash occurred:

If No. **Step 1.** Please indicate the route, roadway and address where the crash occurred:

Route# _____ Name of Roadway/Street _____

The crash occurred on Route #: _____ at Street or Address Number: _____

Step 2. What was the name (or names) of the intersecting streets?

on the Street/Roadway known as _____

Route# _____ Name of Roadway/Street _____

Step 2. Please provide as much of the following specific location information as possible:

Route# _____ Name of Roadway/Street _____

The crash occurred (estimate number of feet) _____ (indicate direction as N/S/E/W) _____

Route# _____ Name of Roadway/Street _____

of: a) Mile Marker number _____ • OR: b) Exit Number _____

Route# _____ Name of Roadway/Street _____

OR: c) Intersecting Street/Roadway _____ Route# Name of Roadway/Street _____

OR: d) Landmark _____

B. Vehicle You Were Driving

B1. Number of occupants in vehicle (including yourself): **B2.** Was vehicle damage above \$1000? Yes No

B3. Driver's License Number	B4. License State	B5. DOB	B6. Age	B7. Sex <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F <input type="checkbox"/> U	B8. License Class <input type="checkbox"/> D <input type="checkbox"/> A <input type="checkbox"/> Unknown <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> M
------------------------------------	--------------------------	----------------	----------------	---	---

B9. Commercial Driver's License Endorsements <input type="checkbox"/> P (Passenger transport) <input type="checkbox"/> T (Doubles/Triples) <input type="checkbox"/> H (Hazardous) <input type="checkbox"/> X (Tank and Hazardous) <input type="checkbox"/> N (Tank vehicles) <input type="checkbox"/> S School Bus	B10. Vehicle Travel Direction <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W
--	--

B11. Your Full Name (Last, First, Middle)	B12. Street Address	City	State	Zip Code
--	----------------------------	------	-------	----------

B13. Insurance Company	B14. Vehicle Registration #	B15. Reg. Type	B16. Reg. State	B17. Vehicle Year	B18. Vehicle Make
-------------------------------	------------------------------------	-----------------------	------------------------	--------------------------	--------------------------

B19. Indicate your type of vehicle <input type="checkbox"/> 4 Bus (16 or more passengers) <input type="checkbox"/> 1 Passenger car <input type="checkbox"/> 5 Bus (9-15 passengers) <input type="checkbox"/> 2 Light truck (van, mini-van, pick-up, sport utility) <input type="checkbox"/> 6 Single-unit truck (2 axles) <input type="checkbox"/> 3 Motorcycle <input type="checkbox"/> 7 Single-unit truck (3 or more axles) <input type="checkbox"/> 8 Truck/trailer	<input type="checkbox"/> 9 Truck tractor (bobtail) <input type="checkbox"/> 10 Tractor/semi-trailer <input type="checkbox"/> 11 Tractor/doubles <input type="checkbox"/> 12 Tractor/triples <input type="checkbox"/> 13 Unknown heavy truck	<input type="checkbox"/> 14 Motor home/recreational vehicle <input type="checkbox"/> 15 Moped <input type="checkbox"/> 16 Low Speed Vehicle	<input type="checkbox"/> 17 All terrain vehicle (ATV) <input type="checkbox"/> 18 Snowmobile <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown
--	---	---	---

B20. Full Name of Vehicle Owner (Last, First, Middle)	B21. Street Address	City	State	Zip Code
--	----------------------------	------	-------	----------

B22. What Was Your Vehicle Doing Prior to the Crash? <input type="checkbox"/> 1 Travelling straight ahead <input type="checkbox"/> 2 Slowing or stopped	<input type="checkbox"/> 3 Turning right <input type="checkbox"/> 4 Turning left	<input type="checkbox"/> 5 Changing lanes <input type="checkbox"/> 6 Entering traffic lane <input type="checkbox"/> 7 Leaving traffic lane	<input type="checkbox"/> 8 Making U-turn <input type="checkbox"/> 9 Overtaking/passing <input type="checkbox"/> 10 Backing	<input type="checkbox"/> 11 Parked <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown
--	---	--	--	--

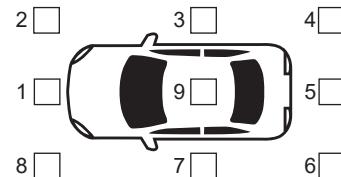
B23. Please Indicate the Sequence of Events as they occurred to YOUR Vehicle by writing the corresponding number (1-52, or 97, 99) in up to 4 boxes below.	What happened first?	Second?	Third?	Fourth?
---	----------------------	---------	--------	---------

Collision with 1 Motor vehicle in traffic 2 Parked motor vehicle 3 Pedestrian 4 Cyclist 5 Animal- deer 6 Animal- other 7 Moped 8 Work zone maintenance equipment	9 Railway vehicle (train, engine) 10 Other movable object 11 Unknown movable object 20 Curb 21 Tree 22 Utility pole 23 Light pole or other post/support 24 Guardrail	25 Median barrier 26 Ditch 27 Embankment/ Sloping shoulder 28 Highway traffic signpost 29 Overhead sign support 30 Fence 31 Mailbox	32 Crash cushion/ Impact attenuator 33 Bridge 34 Bridge overhead structure 35 Other fixed object (wall, building, tunnel) 36 Unknown fixed object	Non-Collision 40 Ran off road right 41 Ran off road left 42 Cross median/ centerline 43 Overturn/rollover 44 Equipment failure (blown tire, brakes, etc) 45 Fire/explosion 46 Immersion	47 Jackknife 48 Cargo/equipment loss or shift 49 Separation of units 50 Downhill runaway 51 Other non-collision 52 Unknown non-collision 97 Other 99 Unknown
---	---	--	--	--	---

B24. Was your Vehicle Towed from the Scene Due to Damage? Yes No

B25. Vehicle Damaged Area (check up to three)

- 0 None
- 10 Undercarriage
- 11 Totaled
- 97 Other
- 99 Unknown



C. You and Your Passengers Please provide the full name, address, and DOB or Age for all passengers in your vehicle. Then write the corresponding code in each of the boxes for each occupant of the vehicle (yourself and all passengers). A list of the possible codes is provided at the bottom of this section.

C1. Passenger 1 (Last, First, Middle)	C2. Address	City	State	Zip Code	C3. DOB	C4. Sex
C5. Passenger 2 (Last, First, Middle)	C6. Address	City	State	Zip Code	C7. DOB	C8. Sex
C9. Passenger 3 (Last, First, Middle)	C10. Address	City	State	Zip Code	C11. DOB	C12. Sex

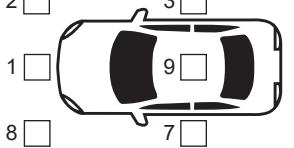
	Seating Position	Safety System Used	Air Bag Status	Ejected From Vehicle?	Trapped?	Injured?	Transported for Medical Care?	Name of Medical Facility
Driver								
Passenger 1								
Passenger 2								
Passenger 3								

Seating Position	Safety System Used	Air Bag Status	
1 Front seat - left side (or motorcycle driver) 2 Front seat - middle 3 Front seat - right side 4 Second seat - left side (or motorcycle passenger) 5 Second seat - middle 6 Second seat - right side 7 Third row - left side (or motorcycle passenger)	8 Third row - middle 9 Third row - right side 10 Sleeper section of cab 11 Enclosed passenger area 12 Unenclosed passenger area 13 Trailing unit 14 Riding on vehicle exterior 97 Other 99 Unknown	0 None used 1 Shoulder and lap belt 2 Lap belt only 3 Shoulder belt only 4 Child safety seat 5 Helmet 97 Unknown	
Ejected From Vehicle?	Trapped?	Injured?	Transported for Medical Care?
0 Not ejected 1 Totally ejected 2 Partially ejected	3 Not applicable 97 Unknown 0 Not trapped 1 Freed by mechanical means 97 Unknown	2 Freed by non-mechanical means 97 Unknown 1 Fatal 7 Suspected serious injury 8 Suspected minor injury 9 Possible Injury 10 No apparent injury	1 Not transported 2 EMS (emergency service) 3 Police 97 Other 99 Unknown

D. Other Vehicle(s) Involved in the Crash

D1. Number of occupants in the Vehicle:	D2. Number of injured occupants	D3. Was Vehicle Damage above \$1000?		□ Yes	□ No	D4. Moped?	D5. Hit and Run?				
		□ Yes	□ No	□ Yes	□ No	□ Yes	□ No				
D6. Driver's License Number		D7. License State	D8. DOB	D9. Age	D10. Sex	□ M	□ X	D11. License Class	□ D	□ A	
						□ F	□ U	□ Unknown	□ C	□ B	□ M
D12. Commercial Driver's License Endorsements		□ P (Passenger transport) □ H (Hazardous) □ X (Tank and Hazardous) □ N (Tank vehicles)			□ T (Doubles/Triples) □ S School Bus			D13. Vehicle Travel Direction			
								□ N	□ S	□ E	□ W
D14. Name of Vehicle Driver (Last, First, Middle)		D15. Street Address			City		State		Zip Code		

D16. Insurance Company	D17. Vehicle Registration #	D18. Reg. Type	D19. Reg. State	D20. Vehicle Year	D21. Vehicle Make
D22. Indicate your type of vehicle		D23. Full Name of Vehicle Owner (Last, First, Middle)		D24. Street Address	
<input type="checkbox"/> 1 Passenger car <input type="checkbox"/> 2 Light truck (van, mini-van, pick-up, sport utility) <input type="checkbox"/> 3 Motorcycle		<input type="checkbox"/> 4 Bus (16 or more passengers) <input type="checkbox"/> 5 Bus (9-15 passengers) <input type="checkbox"/> 6 Single-unit truck (2 axles) <input type="checkbox"/> 7 Single-unit truck (3 or more axles) <input type="checkbox"/> 8 Truck/trailer		<input type="checkbox"/> 9 Truck tractor (bobtail) <input type="checkbox"/> 10 Tractor/semi-trailer <input type="checkbox"/> 11 Tractor/doubles <input type="checkbox"/> 12 Tractor/triples <input type="checkbox"/> 13 Unknown heavy truck	
				<input type="checkbox"/> 14 Motor home/recreational vehicle <input type="checkbox"/> 15 Moped <input type="checkbox"/> 16 Low Speed Vehicle	
				<input type="checkbox"/> 17 All terrain vehicle (ATV) <input type="checkbox"/> 18 Snowmobile <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown	

D25. What Was Your Vehicle Doing Prior to the Crash?	D26. Vehicle Damaged Area (check up to three)
<input type="checkbox"/> 1 Travelling straight ahead <input type="checkbox"/> 2 Slowing or stopped <input type="checkbox"/> 3 Turning right <input type="checkbox"/> 4 Turning left	<input type="checkbox"/> 5 Changing lanes <input type="checkbox"/> 6 Entering traffic lane <input type="checkbox"/> 7 Leaving traffic lane <input type="checkbox"/> 8 Making U-turn <input type="checkbox"/> 9 Overtaking/passing <input type="checkbox"/> 10 Backing <input type="checkbox"/> 11 Parked <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown
	
	<input type="checkbox"/> 0 None <input type="checkbox"/> 10 Undercarriage <input type="checkbox"/> 11 Totaled <input type="checkbox"/> 97 Other <input type="checkbox"/> 99 Unknown

E. Non-Motorist(s) Involved in the Crash

E1. Indicate the type of non-motorist involved 1 Pedestrian 2 Cyclist 3 Skater 97 Other 99 Unknown

E2. What was the non-motorist doing prior to the crash?

<input type="checkbox"/> 1 Entering or crossing location	<input type="checkbox"/> 4 Pushing vehicle	<input type="checkbox"/> 97 Other
<input type="checkbox"/> 2 Walking, running, or cycling	<input type="checkbox"/> 5 Approaching or leaving vehicle	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 3 Working	<input type="checkbox"/> 6 Working on vehicle	
	<input type="checkbox"/> 7 Standing	

E3. Where was the non-motorist prior to the crash?

<input type="checkbox"/> 1 Marked crosswalk at intersection	<input type="checkbox"/> 4 In roadway	<input type="checkbox"/> 8 Shoulder
<input type="checkbox"/> 2 At intersection but no crosswalk	<input type="checkbox"/> 5 Not in roadway	<input type="checkbox"/> 9 Sidewalk
<input type="checkbox"/> 3 Non-intersection crosswalk	<input type="checkbox"/> 6 Median (but not on shoulder)	<input type="checkbox"/> 10 Shared-use path or trails
	<input type="checkbox"/> 7 Island	<input type="checkbox"/> 99 Unknown

E4. Full Name of Non-Motorist (Last, First, Middle)

E5. Street Address

City

State Zip Code

E6. DOB

E7. Sex

E8. Safety Equipment?

<input type="checkbox"/> 0 None used	<input type="checkbox"/> 8 Reflective clothing
<input type="checkbox"/> 6 Helmet	<input type="checkbox"/> 9 Lighting
<input type="checkbox"/> 7 Protective pads (elbows, knees, etc.)	<input type="checkbox"/> 10 Other
	<input type="checkbox"/> 99 Unknown

E9. Injured?

<input type="checkbox"/> 1 Fatal	<input type="checkbox"/> 8 Suspected minor injury
<input type="checkbox"/> 7 Suspected serious injury	<input type="checkbox"/> 10 No apparent injury
	<input type="checkbox"/> 9 Possible Injury

E10. Transported for Medical Care?

<input type="checkbox"/> 1 Not transported	<input type="checkbox"/> 3 Police
<input type="checkbox"/> 2 EMS (emergency service)	<input type="checkbox"/> 97 Other
	<input type="checkbox"/> 99 Unknown

E11. If transported, please indicate Hospital/Medical Facility:

F. Crash Conditions

F1. Light Conditions

<input type="checkbox"/> 1 Daylight	<input type="checkbox"/> 97 Other
<input type="checkbox"/> 2 Dawn	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 3 Dusk	
<input type="checkbox"/> 4 Dark - lighted roadway	
<input type="checkbox"/> 5 Dark - roadway not lighted	
<input type="checkbox"/> 6 Dark - unknown roadway lighting	

F2. Weather Conditions (up to two)

<input type="checkbox"/> 1 Clear	<input type="checkbox"/> 7 Severe crosswinds
<input type="checkbox"/> 2 Cloudy	<input type="checkbox"/> 8 Blowing sand, snow
<input type="checkbox"/> 3 Rain	<input type="checkbox"/> 97 Other
<input type="checkbox"/> 4 Snow	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 5 Sleet, hail, freezing rain	
<input type="checkbox"/> 6 Fog, smog, smoke	

F3. Traffic Control Device

<input type="checkbox"/> 1 No controls
<input type="checkbox"/> 2 Stop signs
<input type="checkbox"/> 3 Traffic control signal
<input type="checkbox"/> 4 Flashing traffic control signal
<input type="checkbox"/> 5 Yield signs
<input type="checkbox"/> 6 School zone signs
<input type="checkbox"/> 7 Warning signs
<input type="checkbox"/> 8 Railroad crossing device
<input type="checkbox"/> 99 Unknown

F4. Road Surface

<input type="checkbox"/> 1 Dry
<input type="checkbox"/> 2 Wet
<input type="checkbox"/> 3 Snow
<input type="checkbox"/> 4 Ice
<input type="checkbox"/> 5 Sand, mud, dirt, oil, gravel
<input type="checkbox"/> 6 Water (standing, moving)
<input type="checkbox"/> 7 Slush
<input type="checkbox"/> 97 Other
<input type="checkbox"/> 99 Unknown

F5. Trafficway Description

<input type="checkbox"/> 1 Two-way, not divided
<input type="checkbox"/> 2 Two-way, divided, unprotected median
<input type="checkbox"/> 3 Two-way, divided, protected median
<input type="checkbox"/> 4 One-way, not divided
<input type="checkbox"/> 99 Unknown

F6. Manner of Collision

<input type="checkbox"/> 1 Single vehicle crash
<input type="checkbox"/> 2 Rear-end
<input type="checkbox"/> 3 Angle
<input type="checkbox"/> 4 Sideswipe, same direction
<input type="checkbox"/> 5 Sideswipe, opposite direction

F7. Roadway Intersection Type

<input type="checkbox"/> 1 Not at intersection	<input type="checkbox"/> 7 Traffic circle
<input type="checkbox"/> 2 Four-way intersection	<input type="checkbox"/> 8 Five-point or more
<input type="checkbox"/> 3 T-intersection	<input type="checkbox"/> 9 Driveway
<input type="checkbox"/> 4 Y-intersection	<input type="checkbox"/> 10 Railway grade crossing
<input type="checkbox"/> 5 On ramp	<input type="checkbox"/> 99 Unknown
<input type="checkbox"/> 6 Off ramp	

F8. Was the traffic control device functioning at the time of the crash? Yes No

F9. School Bus Related? Yes No

F10. Work Zone Related? Yes No

G. Crash Diagram



Indicate North by Arrow

Please draw a diagram of the roadway or streets where the crash occurred, indicating the vehicles involved and direction of travel using the following symbols:

Direction

<input type="checkbox"/> 1	= Vehicle 1 (Your Vehicle)
<input type="checkbox"/> 2	= Vehicle 2
<input type="checkbox"/>	= Pedestrian/Non-motorist
<input type="checkbox"/>	= North

Select one of the following if the crash did not occur on a public way:

<input type="checkbox"/>	Off-street parking lot
<input type="checkbox"/>	Garage
<input type="checkbox"/>	Mall/shopping center
<input type="checkbox"/>	Other private way

H. Witness Information

H1. Witness Name (Last, First, Middle)	H2. Street Address	City	State	Zip Code	H3. Phone
H4. Witness Name (Last, First, Middle)	H5. Street Address	City	State	Zip Code	H6. Phone

I. Property Damage Information (Other than Vehicles)

I1. Owner Name (Last, First, Middle)	I2. Street Address	I3. Phone	I4. Property and Damage Description
I5. Owner Name (Last, First, Middle)	I6. Street Address	I7. Phone	I8. Property and Damage Description

J. Description of What Happened**K. Signature**

"Signed under Pains and Penalties of Perjury"

Print

Date